PRINTED: 10/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPI	LETED
		151335	B. WIN			08/30/2	.011
		<u> </u>	P. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8		1600 23			
ST VINC	ENT DUNN HOSPI	TAL INC		I	PRD, IN47421		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	INIL	DATE
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	This visit was for	r a State licensure survey.	S0	000			
		00.4==0					
	Facility Number	: 004779					
	Datam 0 20 11 4	1					
	Dates: 8-29-11 t	inrough 8-30-11					
	Surveyors:						
	j						
	Billie Jo Fritch, I	RN, BSN, MBA					
	Public Health Nu						
		J					
	Deborah Franco,	RN					
	Public Health Nu						
	Ken Zeigler						
	Laboratory Surve	evor					
	Laboratory Burv	0 , 0.					
	QA: claughlin 0	9/09/11					
	VII. Claugillii 0)/ (V)/ 11					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

004779

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

			(X2) MULTIPLE CONSTRUCTION (X3) DATE		(MS) DATE	JORVET	
		IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		151335	B. WING			08/30/2	011
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TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
S0406	410 IAC 15-1.4-2(a	a)(1)					
50400	(a) The hospital sheffective, organize comprehensive quimprovement prog of the hospital part program shall be owritten plan of impevaluates, but is not following: (1) All services, incompart furnished by a condition of the facility failed including those is contract, in the family and appropriately and appropriately. 1. Review of fact 8-30-11 lacked ensure they are pappropriately. 2. Interview with hours confirmed pediatrics and Effective of pediatrics and Effective of pediatrics and Effective organizer of pediatrics and Effective organizer organizer of pediatrics and Effective organizer organize	nall have an d, hospital-wide, nality assessment and ram in which all areas ticipate. The ongoing and have a lementation that ot limited to, the cluding services tractor. The one of the cluding services and interview, to include all services, ervices provided by acility Quality Assurance. Improvement (QAPI) the they are provided oriately. The cluding services and the direct trics and EEG's and the e of bioengineering were acility QAPI program to rovided safely and the B#3 on 8-30-11 at 1245 that the direct services of EG's and the contracted	S0-2	406	QI for EEG, Pediatric and Biomed (Trimedx) services. 1. Corrective Action: EEG: Morguarterly turn around for timeliness of physician reading (interpretation) of tests Pediated QI: Review of all pediatric records with ongoing data collection for: Assessment daily weights are documented Oxygen saturations are measured every shift when applicable Assessment of immunization status is documented Trimed (Bio-Med) Physical Plant will track 10% or 20 pieces of all equipment with preventive maintanence performed on a quarterly basis. Trimedx will submit the list of this equipment to the Safety Committee on a monthly basis. 2. Preventive Action: EEG: Data collection of EEG timely reading turn aroutime for physician reading	nitor ng tric t of do- sured lx: I	09/19/2011
	•	ineering are not included API program to ensure			(interpretation).Pediatric QI: is collected by the departmer manager and/or the clinical		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S COMPLE		
AND PLAN	OF CORRECTION	151335	A. BUILDING	00	08/30/20	
		101000	B. WING	T ADDRESS, CITY, STATE, ZIP CODE	00/00/20	711
NAME OF P	PROVIDER OR SUPPLIER		ı	23RD ST		
ST VINC	ENT DUNN HOSPIT	TAL INC	1	FORD, IN47421		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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	they are provided safely and appropriately.			support nurses. The departn manager will monitor for any negative trends. See attach data collection sheet. Data i then recorded on the hospita dashboard. Data is also rep	ed is	
				at Quality Council and department meetings on a quarterly basis. Trimedx: Ph Plant will review 10% or no I than 20 PM completions on quarterly basis. Summary w reviewed at Safety Committe Responsibility: EEG: Cardio-Vascular MgrPediatric:Department Manager & Clinical Support Manager Trimedx: Physical Plant4. Completion date: EE Start quarterly data collectio 10/01/11. Pediatric completi date:September 2011. Trime completion date: September 2011.	ysical ess a i/ill be ee 3. EG: n ion edx	
S0556		an active, en hospital-wide rogram. Included in be system designed n, surveillance, rol, and prevention ommunicable				
	Based on docume the facility failed infection control spread of commu	to have an effective program to prevent the unicable diseases to and health care workers.	S0556	Maintaining an efffective Infe Control Program. 1. Correct Action: Document immunity new hires & current associ for MMR & Varicella. 2. Preventive Action: A. New h Revision of the current pre-h	tive for iates nires:	10/01/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	TIPLE CON	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	00	COMPL	
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TAG	Findings include 1. Review of per lacked evidence members (B# 4, 16 and K# 1-10) proof of immunit 2. Review of per lacked evidence members (B# 4, 2 and K# 1-10) had proof of immunit 3. Interview with hours confirmed above personnel staff members do reliable proof of varicella. 4. Interview with hours confirms the control program without documer immunity are preduring a community are preduring a community are preduring a community or varicella in ord of communicable visitors, or other 5. On 8-30-2011 14 personnel file indicated: A. 14 employees	rsonnel files on 8-29-11 that 20 of 21 staff 5, 8, 9, 10, 12, 13, 14, 15, had documented reliable ty to Varicella. rsonnel files on 8-29-11 that 18 of 21 staff 8, 10, 12, 13, 14, 15, 16 d documented reliable		TAG	Lab form to include immun testing for Rubeola & Varicel (Completed 08/31/2011) B. Current associates: Beginni 10/01/2011 Immunity testir all associates for MMR & Varicella. (Both categories w receive immunizations as indicated by immunity testir results.) HR & Employee He Policies will reflect the above revisions. 3. Responsibility: Human Resources Director & Infection Control4. Date of Completion: 30 day increme for immunity testing: October 2011 Last names beginning A and B November 2011 Last names beginning with C thruf December 2011 Last names beginning with G thru L Janua 2012 Last names beginning M thru R February 2012 Last names beginning with S thruful V March 2012 Last names beginning with W thruful ZFinal completion date is 03/31/2015	ity la. ng ng for vill ng alth e with et es iary with et	DATE
	immunization.						
ı	mmuullizaliUll.		1				

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AND PLAN	OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIE	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151335	LDING GSTREET A	ONSTRUCTION OO ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE COMPI 08/30/2	LETED
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	acquired immun B. 14 employee a. reliable of immunization.	documented history of				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

PF1J11

Facility ID: 004779

If continuation sheet

Page 5 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 151335			(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE (COMPL 08/30/2	ETED
	PROVIDER OR SUPPLIER			STREET A 1600 23	DDRESS, CITY, STATE, ZIP CODE RD ST RD, IN47421		
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S0596	and guide the inferogram in the fact (3) The infection or responsibilities should be limited to, the following and in procedures, polywhich are pertinent control. These inclimited to, the following the fact of	all establish an committee to monitor ction control ility as follows: control committee all include, but the following: I recommending changes icies, and programs at to infection clude, but are not wing: If recommending changes icies, and programs at the infection clude, but are not wing: If rection, and If rection, and If rection, and If rection, and If rection techniques in manufacturer's as for Cidex OPA in 1 of 1 as department. If a department. If a department is a department in the infection technique in the infection techniques in the infecti	S02	596	Infection Control: High level Disinfection in Surgical Servi Dept.1. Corrective Action: Associate re-education regar proper documentation of test and usage of High Level Disinfection.2. Preventive Action: weekly audits x 1 mo and then quarterly audits of High Level Disinfection records. Track and counsel associates not compliant wit documentation. Summary rewill be forwarded to Infection Control. 3. Responsibility: Surgical Services Manager4. Date of Completion: 09/01/20	ding ing onth the hoort	09/01/2011

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE COMPL	
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IAG		mmerse the device in the	-	IAU			DATE
	1 1	tion, irrigating any					
		cording to manufacturer's					
		s. Cidex OPA = 12					
	minutes.	5. CIGON 0111 12					
	2. At 12:45 PM	on August 29, 2011 in					
		vices department and in					
	the presence of E	E #1 and E#9, interview					
	with staff member	er E #9 indicated:					
	a. Cidex OPA is	used to disinfect camera,					
	endoscopic lense	s, cystoscopy intruments,					
		nentation not amenable to					
	steam sterilizatio						
		urer's guidelines include					
	instructions that '						
	1 1	ersed for a minimum of					
		stroy all pathogenic					
	microorganisms"						
	c. A log book for						
	i. date	the following headings:					
	ii. item(s)						
	1 ' '	immersion in disinfectant					
	begins)						
		(item removed from					
	disinfecting agen						
		passed and initial of					
	1	sible for assuring the					
	disinfection of						
	the item(s)						
	d. The log book	lacked documentation of					
	compliance with	the manufacturer's					
	guidelines for use	e in the following:					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THETETAL	or conduction	151335	A. BUILDING B. WING		08/30/2011
				ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER		1600 23	3RD ST	
ST VINC	ENT DUNN HOSPI	TAL INC	BEDFC	DRD, IN47421	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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1110		entries of disinfection	1110		DATE
	cycles lacked an entry indicating the time				
	the	, .			
	item(s) were	removed from the Cidex			
	OPA.				
		entries of disinfection			
	-	entry indicating the time			
	the item(s) were	immersed in the Cidex			
	OPA.	mimersed in the Cidex			
	0171.				
	3. Interview at 1	2:45 PM with E #1 and E			
	#9, E #1 and E #	9 confirmed that the			
		and not been followed in			
		ces and that disinfection			
		ermined for items without			
	a "time in" or "ting	me out" entry.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 151335			(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE S COMPL 08/30/2	ETED
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S0612	(f) The hospital shinfection control or and guide the infeprogram in the fact (3) The infection or responsibilities shanot be limited to, the (D) Reviewing and in procedures, polywhich are pertinent control. These inclimited to, the following the following and interview, the program failed to management polyof 2 linen storage. Findings include 1. While touring 1320 hours in the stored in 2 of 2 stobserved to be stopped to be stopped to the storage of the factorial storage. Review of factorial storage of the factorial storage of the storage	all establish an ommittee to monitor ction control ility as follows: ontrol committee all include, but the following: direcommending changes icies, and programs at to infection clude, but are not wing: Internal management for din linen handling. Internal management for din linen handling.	S06		TAG S612 1. Corrective Action: Linen storage is press in transition. Currently movi the laundry equipment out ar dividing the laundry room into soiled linen and cle linen storage areas. 2. Preventative Action: The clinen side will have shelves placed for proper storage of clinen. Until the linen room is completed, linens are stored second floor in empty rooms. The linen will be covered with sheet while we are in this transition. An interim linen storage policy has been written and implemented. Complia will be monitored by the Environmental Services mgr and documented on a checksheet daily x 3 months then quarterly checks x 1 y with reports forwarded to the Safety Committee. 3.	ng all and lean clean on the annoce and ear	08/30/2011

NAME OF PROVIDER OR SUPPLIER ST VINCENT DUNN HOSPITAL INC (X4) ID SUMMARY STATEMENT OF DEFICIENCES BEDFORD, IN47421 SUMMARY STATEMENT OF DEFICIENCES BEDFORD, IN47421 (X5) ID FREFTX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LES IDENTIFYING HOROMATION) TAG REGULATORY OR LES IDENTIFYING HOROMATION) the Central Sterile Supply. The doors of the cabinets must remain closed to protect the linen from dust. 3. Interview with B#5 on 8-30-11 at 1320 hours confirmed the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. 4. Interview with B#8 on 8-30-11 at 1500 hours confirmed the facility policy regarding linen storage, the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas, and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. S0952 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures.	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JETIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
NAME OF PROVIDER OR SUPPLIER ST VINCENT DUNN HOSPITAL INC IXA BID SUMMARY STATEMENT OF DEFICIENCIES PREFIX GEACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LISC IDENTIFYING INFORMATION DATE The Central Sterile Supply. The doors of the cabinets must remain closed to protect the linen from dust. 3. Interview with B#5 on 8-30-11 at 1320 hours confirmed the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stacked on patient stretchers in 2 of 2 linen storage areas, and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stacked on patient stretchers in 2 of 2 linen storage areas, and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. 4. Interview with B#8 on 8-30-11 at 1500 hours confirmed the facility is not following the facility policy regarding linen storage, the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas, and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. S0952 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medical staff policies and procedures. If the blood transfusions and intravenous medical staff policies and procedures. If the blood transfusions and intravenous medical staff policies and procedures. If the blood transfusions and intravenous medical staff policies and procedures. If the blood transfusions and intravenous medical staff policies and procedures. If the blood transfusions and intravenous medical staff policies and procedures are administered by personnel shall have special training for these procedures.	ANDILAN	or connection		1		00		
ST VINCENT DUNN HOSPITAL INC (X2) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) the Central Sterile Supply. The doors of the cabinets must remain closed to protect the linen from dust. 3. Interview with B#5 on 8-30-11 at 1320 hours confirmed the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stacked on patient stretchers in 2 of 2 linen storage, the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas, and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. 4. Interview with B#8 on 8-30-11 at 1500 hours confirmed the facility is not following the facility policy regarding linen storage, the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas, and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. S0952 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medical staff policies and procedures. If the blood transfusions are administered by personnel other than physicians, the personnel shall have special training for these procedures.			101000	B. WING			00/00/2	011
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the cabinets must remain closed to protect the linen from dust. 3. Interview with B#5 on 8-30-11 at 1320 hours confirmed the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. 4. Interview with B#8 on 8-30-11 at 1500 hours confirmed the facility is not following the facility policy regarding linen storage, the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas, and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. S0952 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions are administered by personnel shall have special training for these procedures	TAG		, , , , , , , , , , , , , , , , , , , ,	<u> </u>	TAG			DATE
the linen from dust. 3. Interview with B#5 on 8-30-11 at 1320 hours confirmed the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stacked on patient stretchers in 2 of 2 linen storage, the clean linens are stacked on patient stretchers in 2 of 2 linen storage, the clean linens are stacked on patient stretchers in 2 of 2 linen storage, the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas, and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. Suppose the facility policy regarding linen storage areas, and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. Suppose the linens are stored. Suppose the linens are stored by Braical Plant Dept. on 8/30/11. Plant Director4. Completion Date: 8/30/2011 for interim storage. Note: The two (2) missing ceiling tiles were also replaced by the Physical Plant Dept. on 8/30/11.		the cabinets must remain closed to protect					aı	
the linen from dust. 3. Interview with B#5 on 8-30-11 at 1320 hours confirmed the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. 4. Interview with B#8 on 8-30-11 at 1500 hours confirmed the facility is not following the facility policy regarding linen storage, the clean linens are stacked on patient stretchers in 2 of 2 linen storage areas, and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. S0952 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions are administered by personnel other than physicians, the personnel other than physicians, the personnel shall have special training for these procedures							tion	
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storage areas, and 2 ceiling tiles are missing from the ceiling of one of the rooms where clean linens are stored. S0952 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures		linen storage, the	clean linens are stacked					
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S0952 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures		missing from the	ceiling of one of the					
(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures		rooms where clea	an linens are stored.					
(d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures								
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accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures		(d) Blood transfusi	ions and intravenous					
medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures								
If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures								
intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures		-	-					
physicians, the personnel shall have special training for these procedures								
special training for these procedures		administered by pe	ersonnel other than					
								
		in accordance with subsection (b)(6).					 	
Based on blood transfusion policy S0952 Blood Transfusion 09/01/2011			, ,, ,	So	₉₅₂	Blood Transfusion		09/01/2011
Administration: 1. Corrective			• •					
review, transfusion document Action: Provide quality assurance		· ·						
includes associate compliance			· · · · · · · · · · · · · · · · · · ·	policy for nursing service which includes associate compliance				
the hospital failed to administer monitoring.2. Preventive Action:		the hospital fa	niled to administer			•		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	151335	A. BUII		00	08/30/2011
		101000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/00/2011
NAME OF I	PROVIDER OR SUPPLIER			1600 23		
	ENT DUNN HOSPIT			BEDFO	RD, IN47421	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	blood transfusions in accordance				Development of review proce the Laboratory to review	l l
	with approved	d medical staff			aspects for administration of	I
	policies and procedure for two of				blood products daily. The and/or Department manager	CSN will
	nine patients.				also continue to review documentation post transfus	
	Findings inclu	lings included:			Responsibility: Blood Bani Supervisor with oversight by Laboratory Director. This control is a supervisor with oversight by the control is a supervisor with oversight by the control is a supervisor with the control is a superv	k
	1. The policy,	"Administration of			element was added to the	
Blood and Blood Products",					hospital-wide dashboard. Date of Completion: 09/01/2	
Policy # PC-58, reviewed 9/01/09,				р		
	read:					
	"At the bed	side:two approved				
	transfusionist	must check the				
	following:	The Date & Time				
	of issue					
	V. Blood/B	lood Product				
	Administratio	on:				
	Dstay w	ith the patient the				
	first 15 minut	es of the				
	transfusion,					
	monitoring	g the patient's				
	response and	observing for				
	adverse					
	reactions.					
	Additional	vital signs and the				
	patient's resp	onse will be				
	documente	ed on the flow sheet				
	at 60 minutes	from Start, and				
	every					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATI	E SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMP	PLETED
		151335	B. WIN				2011
			P. ,, 11		ADDRESS, CITY, STATE, ZIP (CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		1600 23	BRD ST		
ST VINC	ENT DUNN HOSP	ITAL INC		BEDFO	PRD, IN47421		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX	.	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	BEITEIERET		DATE
	60 minute	s from that"					
	2. In review of	of two patients					
	receiving blo	od units, three of					
	_	d-units did not have					
	l						
	1 -	umentation, per					
	policy, on the	e Blood Transfusion					
	Flow Sheet fo	orm including:					
	Patient #1						
	l	ministered on 9/26/11					
		ninistered on 8/26/11					
	at 1010: The	unit was					
	issued from t	he laboratory at					
	1052; howeve	er, the start time was					
	listed at 1010	· ·					
		•					
	Patient #5						
	l	ninistered on 8/13/11					
	at 0825: The						
	I	was documented at					
	0915 in lieu o	of 0925.					
	Unit #3 adn	ninistered on 8/13/11					
	at 0900: The	1 hour vital reading					
		ited at 1015 in lieu of					
		icu at 1913 ili licu vi					
	1000.						
	3. On 8/29/11	at 2:00 p.m., staff					
	member #S3	acknowledged the					
	above-listed	missing					
	1	····	ı				1

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
151335		151335	B. WING		08/30/2011	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		ı	23RD ST		
ST VINC	ENT DUNN HOSPIT	TAL INC		ORD, IN47421		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	documentatio	n.				
S1118	410 IAC 15-1.5-8	(b)(2)				
	(b) The condition of					
	plant and the over					
	environment shall	n a manner that the				
	safety and well-be					
	assured as follows	- ·				
	(2) No condition shall be created or					
	maintained which					
	hazard to patients	, public, or				
	employees.			1		
	Based on observa	ation and interview, the	S1118	Emergency call cords not	08/30/2011	
	facility created/n	naintained conditions		accessible in public rest ro	oms	
	which could resu	It in hazards to patients,		and unsecured fire		
	visitors, and staff	f in 3 of 3 restrooms and		extinguishers in the maintenance department. 1		
	1 of 1 maintenan			Corrective action: Call cords		
	1 01 1 111011110	•		repaired to a shorter length a		
	Eindings in dude			untied on 8/30/2011. Addition		
	Findings include			- House keepers were		
				educated on 09/13/11 to che	eck	
	_	the facility on 8-30-11		the cords to determine if		
		ours and 1400 hours, in		properly working when roon		
	the presence of E	3#5, 2 restrooms outside		cleaned. Fire extinguished		
	the radiology dep	partment and one		were secured on 08/30/2011 Preventative action: Assign		
	restroom outside	the cafeteria area were		housekeepers to check the		
		the emergency pull		cords for accessibilitydu		
		0 7 1		normal cleaning. Env Serv	9	
	cords wrapped tightly around the grab bars; pulling on the emergency cords was			Mgr. will check complian	ice	
				monthly x 3 months , then		
unsuccessful in activating the emergency enunciator or emergency light resulting in				quarterly x 1 year. Repo	rts	
				will be forwarded to Safety		
	a hazard to patien	nts, visitors, and staff if		Committee on a quarter	•	
	emergency help	were needed.		basis. 3. Responsibility of	f:	
	2. While touring	the maintenance		Environmental Services		
	- · · · · · · · · · · · · · · · · · · ·	,		Manager and		

004779

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED	
		151335	B. WING			08/30/201	1
NAME OF P	ROVIDER OR SUPPLIER	L	•		DRESS, CITY, STATE, ZIP CODE		
ST MINICI	ENT DUNN HOSPI	TAL INC	I	00 23F	RD ST RD, IN47421		
				DFOR	.D, 11147421		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	- 1	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG			IAC	J	Plant Operations		DATE
	department on 8-30-11 at 1055 hours in the presence of B#5, 2 unsecured fire			Manager. 4. Date corrected:		.	
	•	·			8-30-2011.		
	_	ere observed on the floor					
		to visitors and staff.					
		h B#5 on 8-30-11 at 1055					
	hours confirmed						
	_	ere on the floor in the					
	maintenance dep						
	emergency pull c						
	tightly around the						
	outside the radio						
	restroom outside						
	not be activated b						
	causing a hazard						
	staff.						
S1166	410 IAC 15-1.5-8(d)(2)(C)					
	(d) The equipment follows:	t requirements are as					
	(2) There shall be						
	equipment and spa						
	safe, effective, and						
	of the available se	ervices to patients,					
	as follows:						
	(C) Appropriate re	ecords shall be					
	kept pertaining to						
	maintenance, repairs, and current						
	leakage checks. Based upon d	ocument review and	S1166		Blood Bank refrigerator ala	rm (09/28/2011
	•	v, the laboratory			testing policy. 1. Corrective action: Revise PM procedures to include recording		
		re the blood bank					
					temperatures. 2. Preventative		
	alarm had been properly maintained and in working order			action : Educate Bio med staf of changes. Lab Policy for		aff	
					Blood Bank PM procedure v	vas	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 151335		A. BUILD		00	(X3) DATE SURVEY COMPLETED 08/30/2011		
	PROVIDER OR SUPPLIER		B. WING O0/30/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1600 23RD ST BEDFORD, IN47421				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
for three of three quarters in 2010 and 2011.					correct; requested TriMede add to their template; Lab modified process to review BioMed completed tasks.	that	
	1. The policy, "Refrigerator Alarm Testing Policy", Policy # BB 39, approved 7/08/11, read: "The hospital maintenance department performs the routine alarm checks for the Blood Bank refrigerator. The testing procedure includes a low temperature activation which should be no lower than 1 degree Centigrade (C)"				Email sent to Trimedx day of survey. Blood Mgr mgr. will add the PM check to month Blood Bank QA report and forward report to Safety Committee monthly x 1 year Responsibility of: TriMedx (Bio-medical staff). in-hous responsibility Blood Bank Supervisor. 4. Date corrected 9-28-2011	r. 3.	
	bank refriger 11/01/10, 3/08 6/11/11 respect indicate the to pen respondent temperature or refrigerator of	ee quarterly ests for the blood ator, dated					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 151335		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/30/2011	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE 3RD ST	
ST VINCI	ENT DUNN HOSPIT	TAL INC		DRD, IN47421	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE
	member #S12	acknowledged this			
	missing docur	nentation.			
S1168	410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows:				
	(3) Defibrillators shat least in accorda	nce with			
	manufacturers rec discharge log with shall be maintaine				
	Based on observa	ation, document review	S1168	Defibrillator daily testing. 1	
	· ·	e facility failed to ensure		Correction action: Docume daily testing. 2. Preventativ	
	that 1 of 1 defibi	ward was discharged at		action : Educate staff to	
	•	ce with manufacturers		perform daily testing and document testing.	
	recommendation			Defibrillators are discharge	
	Findings included	d:		daily The assigned day sh Med/Surg Code Team nurse performs and document	•
	1. On August 29	, 2011 at 2:10 PM during		the user test daily. · The assigned night shift Med/So	ırg
	tour of the medical/surgical unit and in the			code team nurse will verify	
	•	, the crash cart was		performance of the daily us test. If it has not been	er
		ain a maintenance		completed, this nurse will t	hen
	· ·	ch lacked documentation t performance in the year		perform and document the	
	2011 for:	e portormance in the year		user test completion. 3. Responsibility: Clinical	
	a. 9 dates in January			Support Nurse and Dept.	
	b. 10 dates in Fe	•		Mgr.4. Date of completion:	
	c. 8 dates in March		9-06-2011		
	d. 7 dates in Ap				
	e. 5 dates in Ma	ay			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ		NSTRUCTION 00	(X3) DATE	ESURVEY	
11112 12111	151335		- 1	LDING		08/30/	
			B. WIN				- * -
NAME OF P	PROVIDER OR SUPPLIEF	R		1600 23			
	ENT DUNN HOSPI			1	RD, IN47421		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX	·	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	BEFFERET		DATE
	g. 6 dates in Ju	-					
	h. 7 dates in A	ugust					
	2. Medtronic LI	FEPAK 12 Operating					
		e the recommended					
	maintenance sch	edule includes:					
	a. "User Test" t	o be completed daily.					
		t, when selected and					
	activated, perfor	rms self-tests; charges to					
	10 Joules and dis	scharges internally; and					
	prints a Pass/Fai						
	•	•					
	3. Interview wit	h E #1 on 08/30/11 at					
	2:15 PM confirm	ned lack of					
	documentation.						

NAME OF PROVIDER OR SUPPLIER ST VINCENT DUNN HOSPITAL INC (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) S1172 410 IAC 15-1.5-8(e)(1)(A)(B)(C) (e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows: (1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following: (A) Asepsis (B) Cross-infection; and (C) Safe practice.	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		E SURVEY		
NAME OF PROVIDER OR SUPPLIER ST VINCENT DUNN HOSPITAL INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES TAG REGULATORY OR LISC IDENTIFYING INFORMATION) S1172 410 IAC 15-1.5-8(e)(1)(A)(B)(C) (e) The building or buildings, including fixtures, walls, floors, ceiling, and furnishings throughout, shall be kept clean and orderly in accordance with current standards of practice as follows: (1) Environmental services shall be provided in such a way as to guard against transmission of disease to patients, health care workers, the public, and visitors by using the current principles of the following: (A) Asepsis (B) Cross-infection; and (C) Safe practice. Based on observation and interview, the facility failed to maintain the ceiting tiles in appropriate order in 1 of 1 housekeeping departments to maintain cleanliness and order. Findings include: 1. While touring the facility on 8-30-11 at 1325 hours, in the presence of B#5, 2 ceiling tiles were observed to be missing from the ceiling in the housekeeping area; one of the missing icelling tiles was propped against the wall below the area of the missing ities with a large dark brown stain on the tile. 2. Interview with B#5 on 8-30-11 at 1325	AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BUILDING 00		COMPLETED		
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	51172	(e) The building or fixtures, walls, floor furnishings throug clean and orderly current standards follows: (1) Environmental provided in such a against transmissi patients, health capublic, and visitors current principles (A) Asepsis (B) Cross-infectio (C) Safe practice. Based on observate facility failed to a in appropriate or housekeeping decleanliness and of the missing tiles were from the ceiling against the missing tiles stain on the tile.	buildings, including ors, ceiling, and hout, shall be kept in accordance with of practice as services shall be away as to guard on of disease to be workers, the soby using the of the following: n; and ation and interview, the maintain the ceiling tiles der in 1 of 1 partments to maintain order. the presence of B#5, 2 to observed to be missing in the housekeeping area; are ceiling tiles was the wall below the area of with a large dark brown	S1	172	housekeeping areas.1. Corrective Action: Replace stained ceiling tiles.2. Preve Actions: Educate Plant Operations staff on importance of replacing tiles Physical Plant staff will repo and place work tickets to replace stained tiles on a timbasis. 3. Responsibility: Pla Operations Manager and Educations to monitor on monthly rounding. This report is forwato Safety Committee on a quarterly basis. 4. Date of	rt nely nt DC	09/28/2011
		hours confirmed	there are 2 missing					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 151335		A. BUILDING 00 B. WING 0			COMPLETED 08/30/2011		
NAME OF PROVIDER OR SUPPLIER ST VINCENT DUNN HOSPITAL INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 23RD ST BEDFORD, IN47421				
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